STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155328	A. BUILDING 01 B. WING	08/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPARK REHABILITATION CENTER	25 S BOEHNE CAMP ROAD EVANSVILLE, IN47712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 08/10/11 Facility Number: 000221 Provider Number: 155328 AIM Number: 100267620 Surveyor: Lex Brashear, Life Safety Code Specialist At this Life Safety Code survey, Westpark Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and was fully	K0000	The Preparation or execution of this plan of correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. The plan of correction is prepared and executed solely because it is required by federal and state law. We respectfully request this Plan of Correction serve as our allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms in the B and C halls. The facility has a capacity of 115 and had a census of 95 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/12/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0029 SS=F	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 5 of 15 hazardous area room doors, such as rooms over 50 square feet containing	K0029	K 029 The 5 identified hazardous room doors have been equipped with self closing devices.	08/19/2011

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	combustible material and a kitchen, were equipped with self closing devices on the doors. This deficient practice could any of the 95 residents, as well as staff and visitors while in the Dining Room, as well as several areas throughout the facility. Findings include: Based on observations on 08/10/11 between 11:15 a.m. and 1:15 p.m. during a tour of the facility with Maintenance Supervisor, the following hazardous area room doors were not provided with self closing devices: a. The two kitchen doors to the Dining Room. b. The south wing Storage Room behind the Nurses' Station which contained several cardboard boxes, paper, and a large plastic paper shredder container full of paper. c. The southwest wing Supply Room door which was full of cardboard boxes. d. The north wing Linen Room which was full of cardboard boxes, clean linens, and other cloth		A one time facility audit was completed to identify hazardous area room doors that are not equipped with self closing devices. No additional doors were identified. Maintenance director was educated on hazardous area room doors that require self closing devices. Prior to changes made to doors and or the use of rooms for storage, the requested change will be reviewed and approved by the Administrator. All requested changes to doors and or use of rooms for storage will be reviewed by the Inter Disciplinary Team and approved by the Administrator with changes reviewed during monthly QA for additional recommendations. Systemic changes will be completed by 8-19-11.	

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	items. These were acknowledged by the Maintenance Supervisor at the time of each observation. 3.1-19(b)			